

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



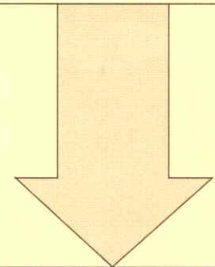
DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				

DATE			
LAST NAME		FIRST	M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO



DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	



GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:		
RELATIONSHIP:		
YOU WERE REFERRED TO US BY		
NAME:		
PERSON TO CONTACT FOR EMERGENCY		
NAME:		
CELL NUMBER		
HOME NUMBER		
ADDRESS		
CITY	STATE	ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
- 6 Cell Phone: ☐ I consent to the dental practice using my cell phone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) _____

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Patient Name _____

MEDICAL HISTORY

Patient Account No. _____

Medical Alert _____

1. Physician's Name _____ Phone () _____
 Have you had any medical care within the past two years? Yes No
 Describe _____
2. Have you taken any medication or drugs during the past two years? Yes No
 If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes No
 If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? Yes No
 If yes, please list name and dosage _____
5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No
 If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.
- | | | | | | | | | |
|--|-----|----|-------------------------------|-----|----|----------------------------------|-----|----|
| Heart (Surgery, Disease, Attack)... | Yes | No | Ulcers | Yes | No | Hepatitis A B C (circle) .. | Yes | No |
| Chest Pain | Yes | No | Diabetes | Yes | No | Venereal Disease | Yes | No |
| Congenital Heart Disease | Yes | No | Thyroid Problems | Yes | No | A.I.D.S./H.I.V. Positive | Yes | No |
| Heart Murmur | Yes | No | Glaucoma | Yes | No | Cold Sores/Fever Blisters | Yes | No |
| High/Low Blood Pressure | Yes | No | Contact lenses | Yes | No | Blood Transfusion | Yes | No |
| Mitral Valve Prolapse | Yes | No | Emphysema | Yes | No | Hemophilia | Yes | No |
| Artificial Heart Valve/Pacemaker | Yes | No | Chronic Cough | Yes | No | Sickle Cell Disease | Yes | No |
| Rheumatic Fever | Yes | No | Tuberculosis | Yes | No | Bruise Easily | Yes | No |
| Arthritis/Rheumatism | Yes | No | Asthma | Yes | No | Liver Disease/Yellow Jaundice .. | Yes | No |
| Cortisone Medicine | Yes | No | Hay Fever/Allergy/Hives | Yes | No | Neurological Disorders | Yes | No |
| Swollen Ankles | Yes | No | Latex Sensitivity | Yes | No | Epilepsy or Seizures | Yes | No |
| Stroke | Yes | No | Sinus Trouble | Yes | No | Fainting or Dizzy Spells | Yes | No |
| Diet (Special/Restricted) | Yes | No | Radiation Therapy | Yes | No | Nervous/Anxious | Yes | No |
| Artificial Joints (hip, knee, etc.) | Yes | No | Chemotherapy | Yes | No | Psychiatric/Psychological Care.. | Yes | No |
| Kidney Trouble | Yes | No | Tumors | Yes | No | Cancer | Yes | No |
8. Have you lost or gained more than 10 pounds in the past year? Yes No
9. Do you have or have you had any disease, condition, or problem not listed? Yes No
 If yes, please list: _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____



Thank you for choosing Redford Dental Group. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options.

Payment Options:

You can choose from:

- Cash, Visa, Mastercard, American Express, Discover Card
- Convenient monthly payment options from Care Credit

Payment in full is due at the time service is rendered. We also offer an in-house savings plan to all of our patients.

Patients who have Dental Insurance coverage that pays the office:

All charges incurred are the responsibility of the patient or their guarantor, NOT the Insurance Company. We must emphasize that as your Dental Care Provider, our relationship is with you, not your insurance company. Our office does not guarantee that your Insurance Company will assist with payment for dental treatment. If your claim is not paid in 60 days, denied, or paid at a lesser amount, you will be responsible for paying the full amount.

We recommend treatment based on our patient's dental needs, not based on Insurance coverage. We estimate what the insurance will pay based on information that they have provided us. What the insurance actually pays will be determined when they process the claim. The estimated patient's portion is due and payable at the start of treatment and if the insurance pays less than estimated, we will bill the remainder to the patient or guarantor.

Please note:

Redford Dental Group requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. A fee of \$50.00 is charged for patients who miss or cancel within 48-hour notice. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian's signature

Date

Patient Name (PLEASE PRINT)

Date

Acknowledgement of receipt of Notice of Privacy Practices

****You may refuse to sign this acknowledgment****

I _____, have received a copy of Notice of Privacy Practices.

Signature

Print Name

Date

If this acknowledgement was signed by a person representative on behalf of the patient, please complete the following:

Person Representative's Name

Person Representative's Signature

Relationship to patient

For Front Staff use only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining the acknowledgement

Other (please specify) _____